International Brotherhood of Electrical Workers
Local 716 Electrical Medical Trust-Houston, Texas

Electrical Medical Trust
Fund Office
8441 Gulf Freeway
Houston, Texas 77017
Phone: 713-643-9300
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November 1, 2024

RE: Dental Benefits

To: All Participating EMT Members

The Board of Trustees of the Electrical Medical Trust are happy to announce the addition of a new Dental Benefit that will become effective on January 1st, 2025. The dental provider will be United Health Care who has provided the included schedule of benefits.

If you have any further question, please don't hesitate to contact our office.

Respectfully yours,
The Board of Trustees

UnitedHealthcare Insurance Company (30100)® Dental Plan

Contributory Options PPO 20 / covered dental services New Standard/90P98/MAC

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	$1,000 per person per Calendar Year	$1,000 per person per Calendar Year	$1,500 per person per Lifetime	$1,500 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Child Only (Up to Age 19)	

COVERED SERVICES *	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	100%	
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleaning)	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (Preventive)	100%	100%	
Sealants	100%	100%	
Space Maintainers	100%	100%	
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	80%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	80%	80%	
Simple Extractions	80%	80%	
Oral Surgery (incl. surgical extractions)	Split Class	Split Class	
Oral Surgery – Brush Biopsy	80%	80%	
Oral Surgery – Other	80%	80%	
Periodontics	80%	80%	
Endodontics	80%	80%	
MAJOR SERVICES			
Oral Surgery (incl. surgical extractions)	Split Class	Split Class	See Exclusions and Limitations section for benefit guidelines.
Oral Surgery – Surgical Extractions	50%	50%	
Oral Surgery – Partial/Fully Bony	50%	50%	
Inlays/Onlays/Crowns	50%	50%	
Dentures and Removable Prosthetics	50%	50%	
Fixed Partial Dentures (Bridges)	50%	50%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.
***The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider. For a complete list of amounts, please refer to your Certificate of Coverage.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

A. Necessary;

B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment, and

D. Not excluded as described in the Section entitled. General Exclusions.

GENERAL LIMITATIONS

1 PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

5 DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.

10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

11 INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

12 CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

13 POST AND CORES Covered only for teeth that have had root canal therapy.

14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.

23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.

24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

25 GENERAL ANESTHESIA Covered only when clinically necessary.

26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

29 CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups sitused in the state of Arizona, in order to comply with state regulations.
22. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
25. Foreign Services are not Covered unless required as an Emergency.
26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
27. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

BENEFITS ENROLLMENT

January 1, 2025 – December 31, 2025

****Please submit form regardless of any changes****

For more information, please visit : www.ElectricalMedicalTrust.com

PERSONAL DATA

Employee Name (First, Middle Initial, Last)		**Last Four of Social Security Number**	**Date of Birth** (MM/DD/YYYY)
Home Address	**City**	**State**	**ZIP Code**
Home Phone #	**Gender** ☐ Male ☐ Female	**Marital Status** ☐ Single ☐Married ☐ Divorced ☐Widowed	**Current Employer/ Local #**

DEPENDENT DATA

Name (First, MI, Last)	**Relationship**	**Last Four of Social Security Number**	**Birth Date** MM / DD / YYYY	**Gender**
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female

NOTE: *Documentation must be provided when adding spouses and/or dependents - marriage license, birth certificate, etc.*

MEDICAL

At the time of hire, or if you are already employed, please notify your employer of your plan election

KELSEY HMO $750 DED	MEMORIAL HERMANN ACO $1,000 DED	CHOICE POS II PPO $2,000 DED
☐ **no employee cost**	☐ **$1.00/hr through payroll deduction**	☐ **$4.00/hr through payroll deduction**

AUTHORIZATION

With this benefit election form, I hereby authorize my employer to make deductions from my paycheck for my medical elections.
I understand that:

- I cannot change this election during the Plan Year unless I have a change in family status, (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse) and such other events as the Plan Administrator determines will permit a change or revocation of an election.
- During Open Enrollment of each year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new form, my current benefit elections will continue to be effective for the new Plan Year.

Employee Signature _____ **Date** _____

Return completed forms to: Yolanda Villalvazo • YVillalvazo@benefitresourcesinc.com • 713-643-9300 • Fax: 866-316-4794
Electrical Medical Trust • 8441 Gulf Freeway, Suite 304 • Houston, TX 77017

ELIGIBILITY AND ENROLLMENT

Initial Eligibility:

- 375 hours during a period of 3 consecutive months, eligible for benefits the 1st day of the 2nd calendar month following that 3-month period; or
- Total of at least 500 hours are contributed during a period of 6 consecutive months, eligible 1st day of the 2nd calendar month following that 6-month period.
- You and your eligible dependents will become initially eligible on the 1st day of the 2nd month following any 3 consecutive calendar months in which you have worked at least 375 hours for Contributing Employers.
- You must enroll your dependents or they will lose their eligibility to participate in the health plan.

Maintenance of Eligibility:

Reserve Account (Hour Bank) – hours worked in excess of 140 per month will be credited to the Reserve Account with a maximum of 560 Reserve hours.

Monthly Deductions from Reserve Account:

140 hours are deducted from the Active Member's Reserve Account for each month of coverage. A lag month will be used in determining continuing eligibility, i.e., June hours are worked for August eligibility.

Termination for Active Members:

- Last day of the month member has less than 140 hours in Reserve Account
- 31st day Collective Bargaining Agreement no longer provides continued remittance of employer contributions

Reinstatement:

Member must post 140 hours within a 6-month period immediately following such termination. Reinstatement will take place on the 1st day of the month following the month requirement is met. If Reserve Account does not show 140 hours within such 6-month period all hours will be forfeited unless coverage is continued through self payment. Once a Reserve Account has been forfeited for this reason Active Member will have to meet the Initial Eligibility requirements again.

Continuation During Total Disability:

With prior approval total disability continuing for 30 days or more will not have any hours deducted from the Member's Reserve Account from the 1st day of the month disability commences. Coverage will be continued up to 3 consecutive months. After that 3 month period the Reserve Account will be used. Once the Reserve Account is depleted, the Member may then continue coverage through self-pay provisions.

Eligibility for Dependents:

Your lawful spouse and eligible children up to age 26.

Non-Bargaining Employees:

Employer must contribute 173 hours per month for each Non–Bargaining Employee.

Non-Bargaining Employees Loss of Eligibility for Insufficient Hours:

Once a Non-Bargaining Employee loses eligibility due to a reduction or insufficient hours, coverage may be continued through the self-pay provisions of COBRA.

Enrollment for the Newly Eligible:

- You will need Social Security Number and Date of Birth for all covered family members.
- You should confirm your health care providers participate in the insurance plan before making an appointment.
- You will receive a detailed benefit booklet and ID card at your home after you have enrolled.
- If you have become eligible for the first time and are enrolling in the medical plan, you may be asked to send a HIPAA Certificate of Creditable Coverage to the Fund Office.

A time of hire, or if you are already employed, please notify your employer of your plan election.*

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2025-12/31/2025

aetna® ELECTRICAL MEDICAL TRUST : HMO - KelseyCare

Coverage for: Individual + Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	KelseyCare In-Network: Individual $750 / Family $2,250.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	KelseyCare In-Network: Individual $5,000/ Family $10,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of KelseyCare In-Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		KelseyCare In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible doesn't apply	Not covered	None
	Specialist visit	$35 copay/visit, deductible doesn't apply	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit, deductible doesn't apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$200 copay/visit, deductible doesn't apply	Not covered	None
If you need drugs to treat your	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		KelseyCare In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Specialty drugs	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance for hospital facility; except $35 copay/visit, deductible doesn't apply for free standing facility	Not covered	None
	Physician/surgeon fees	20% coinsurance for hospital facility; no charge for free standing facility	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$50 copay/visit, deductible doesn't apply	Not covered	No coverage for non-urgent use.
	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		KelseyCare In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $35 copay/visit, deductible doesn't apply	Not covered	None
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	$35 copay/pregnancy, deductible doesn't apply	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	60 visits/calendar year.
	Rehabilitation services	$35 copay/visit, deductible doesn't apply	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	$35 copay/visit, deductible doesn't apply	Not covered	None
	Skilled nursing care	20% coinsurance	Not covered	60 days/calendar year.
	Durable medical equipment	No charge	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **No.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$750**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,520**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$750**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$750**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,160**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

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Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

aetna® ELECTRICAL MEDICAL TRUST : Aetna Open Access® Aetna SelectSM - MEMORIAL HERMAN ACO

Coverage Period: 01/01/2025-12/31/2025

Coverage for: Individual + Family | Plan Type: EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Memorial Hermann In-Network: Individual $1,000 / Family $3,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Memorial Hermann In-Network: Individual $5,000 / Family $10,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of Memorial Hermann In-Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Memorial Hermann In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible doesn't apply	Not covered	None
	Specialist visit	$30 copay/visit, deductible doesn't apply	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay/visit, deductible doesn't apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	Not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Memorial Hermann In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance for hospital facility; except $30 copay/visit, deductible doesn't apply for free standing facility	Not covered	None
	Physician/surgeon fees	25% coinsurance for hospital facility; no charge for free standing facility	Not covered	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	Emergency medical transportation	25% coinsurance	25% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$50 copay/visit, deductible doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $30 copay/visit, deductible doesn't apply	Not covered	None
	Inpatient services	25% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	25% coinsurance	Not covered	
	Childbirth/delivery facility services	25% coinsurance	Not covered	
If you need help recovering or have	Home health care	25% coinsurance	Not covered	60 visits/calendar year combined with private-duty nursing.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Memorial Hermann In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs	Rehabilitation services	$30 copay/visit, deductible doesn't apply	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	$30 copay/visit, deductible doesn't apply	Not covered	None
	Skilled nursing care	25% coinsurance	Not covered	60 days/calendar year.
	Durable medical equipment	25% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	25% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing - Included as part of home health care.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **No.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,570**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,410**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2025-12/31/2025

aetna® ELECTRICAL MEDICAL TRUST : Aetna Choice® POS II - $2000

Coverage for: Individual + Family | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $2,000 / Family $6,000. Out-of-Network: Individual $3,000 / Family $9,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits & preventive care are covered before you meet your deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $5,000 / Family $10,000. Out-of-Network: Individual $10,000 / Family $20,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	$55 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$45 copay/visit, deductible doesn't apply	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	Not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$50 copay/visit, deductible doesn't apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $55 copay/visit, deductible doesn't apply	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	60 visits/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$55 copay/visit, deductible doesn't apply	50% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$55 copay/visit, deductible doesn't apply	50% coinsurance	None
	Skilled nursing care	30% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	30% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	30% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/24 months for in-network only.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **No.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist copayment	**$55**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$300
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$4,770**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist copayment	**$55**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,800**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist copayment	**$55**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,210**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

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Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2025-12/31/2025

aetna® ELECTRICAL MEDICAL TRUST : Open Choice® - OOA Dep PPO

Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $750 / Family $2,250. Out-of-Network: Individual $3,000 / Family $9,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $6,850 / Family $13,700. Out-of-Network: Individual $10,000 / Family $20,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	$35 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit, deductible doesn't apply	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$200 copay/visit, deductible doesn't apply	50% coinsurance	None
If you need drugs to treat your	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Specialty drugs	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$50 copay/visit, deductible doesn't apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $35 copay/visit, deductible doesn't apply	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	60 visits/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$35 copay/visit, deductible doesn't apply	50% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	$35 copay/visit, deductible doesn't apply	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child)	• Glasses (Child) • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S.	• Prescription drugs • Private-duty nursing • Routine foot care • Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care - 20 visits/calendar year.	• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.	• Routine eye care (Adult) - 1 routine eye exam/24 months for in-network only.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? No.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$750**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,920**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$750**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$750**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,160**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-800-370-4526.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-800-370-4526
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.
Bengali-Bangala -	আপনাকে বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-888-982-3861
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.
Burmese -	သင့်အေနျဖင့် အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မွမ်ား ရရွိးုိင္ရန္ 1-800-370-4526 သို့ ဖုန္းေခၚဆုိပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Cherokee -	ᏩᎩᏍᏗ ᏚᎾᏂᎯᏍᏗ ᎤᏪᎾᏓᏁᏗ ᏝᎪᎢᏍᏗ ᏗᏩEᏩᎳᏁᏗ ᎯᎩ, ᏫᏥᎯᏰᎳᏓᏆ 1-800-370-4526.
Chinese -	如欲使用免費語言服務，請致電 1-800-370-4526.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોંચ માટે, કોલ કરો1-800-370-4526.

Your KelseyCare Plan in Action

KelseyCare® aetna™

Your Health

- When you choose the **KelseyCare Aetna Plan**, you select Kelsey-Seybold doctors as your healthcare providers.
- See any of the more than 500 Kelsey-Seybold physicians you want with no referral required – at any of our 27 Houston-area locations.
- Kelsey-Seybold physicians can refer to more than 7,000 affiliated medical specialists, and admit to prominent hospitals including Texas Children's Hospital, St. Luke's Health, the Texas Heart Institute, The Woman's Hospital of Texas, select Houston Methodist and Memorial Hermann facilities, and many more.
- Kelsey-Seybold uses a state-of-the-art electronic medical record, so your medical record follows you to any Kelsey-Seybold location.

Your Convenience

- 24/7 appointment scheduling: Call 713-442-0000.
- Same-day and next-day appointments with primary care doctors.
- After-Hours Kelsey-Seybold Nurse Hotline – 365 days a year at 713-442-0000.
- Go to any location, see any primary care doctor or specialist, no referral required.
- No running from place to place: Physicians, lab services and routine X-ray available at **all** Kelsey-Seybold Clinic locations and an on-site Kelsey Pharmacy at many locations.
- Saturday appointments from 9 a.m. to 2 p.m. at four locations.

For help with any questions about care at Kelsey-Seybold, contact your KelseyCare Concierge:

Monday - Friday: 8 a.m. to 5 p.m.

713-442-9593

Your MyKelseyOnline

MyKelseyOnline (MKO) keeps you connected with Kelsey-Seybold 24/7. With MKO you can:

- Schedule appointments with primary care doctors and a growing number of medical specialties.
- Email your doctor's office.
- Check family medical records.
- Get most test results.

MyKelseyOnline Help Line:

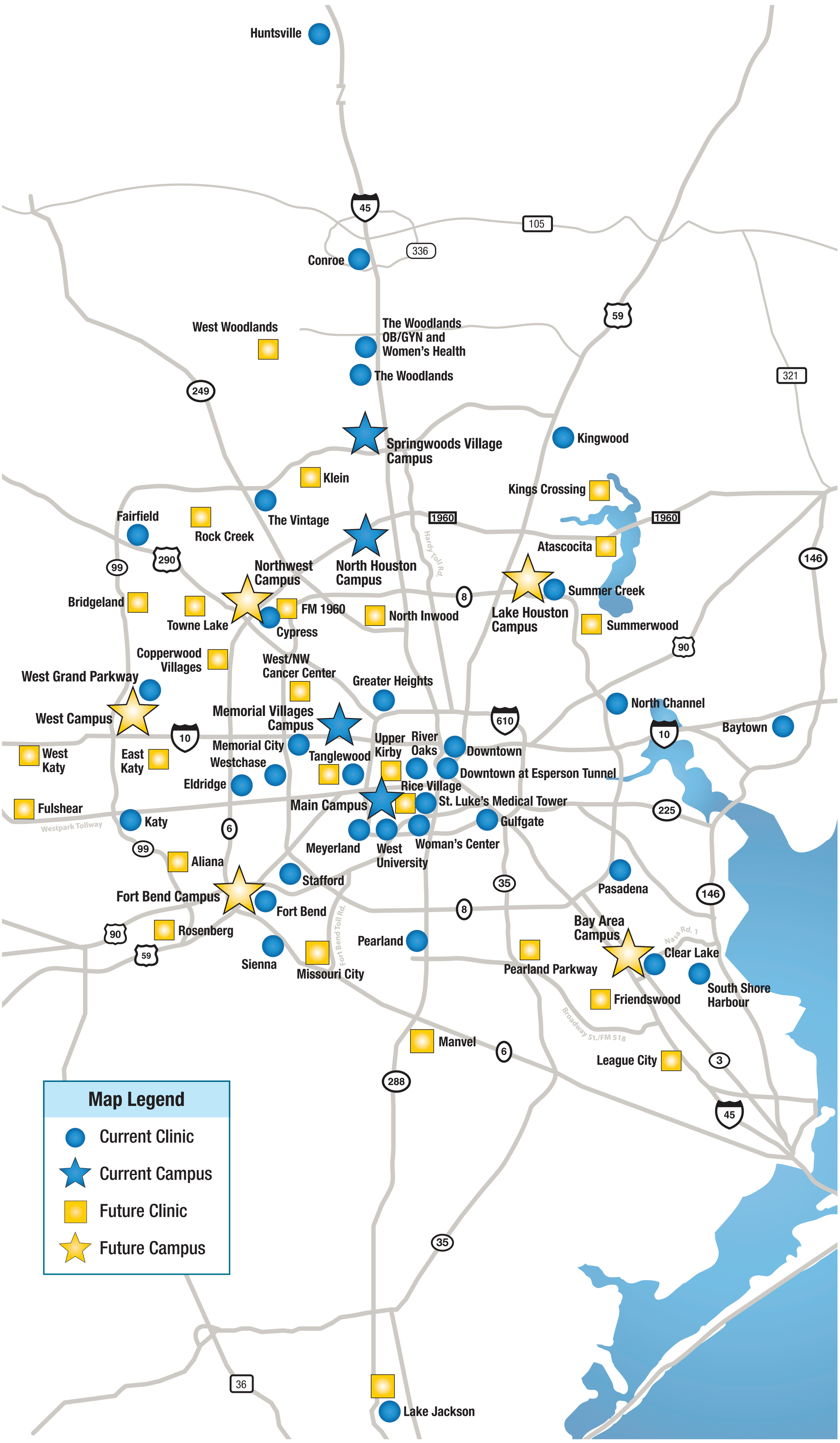
Monday - Sunday: 7 a.m. to 9 p.m.

713-442-6565

MyKelseyOnline.com

Kelsey-Seybold Clinic®

Current and Future Campus and Clinic Locations



Map Legend

- Current Clinic
- Current Campus
- Future Clinic
- Future Campus

2025/2026
18 NEW Locations

- Towne Lake
- Missouri City
- League CIty
- Klein
- West Katy
- West/NW Cancer Center
- Copperwood Villages
- Fulshear
- Rock Creek
- North Inwood
- Kings Crossing (Kingwood)
- East Katy
- Manvel
- Bridgeland
- Friendswood
- Summerwood
- West Main
- East River

Updated on 08.31.23

Kelsey-Seybold Virtual Health

Efficient • Convenient • Kelsey-Seybold Quality

365 Days a Year! Days, Evenings, and Weekends

Primary & Specialty Care Video Visits

Have a real-time conversation with a Kelsey-Seybold board-certified provider.

Primary Care

50 Conditions
Adult Video Visits (18 years+)

- Cold/flu
- Ear infection
- Eczema
- GERD
- Bladder infection
- Sore throat
- Laryngitis
- Shingles
- Sprained ankle/knee
- Pink eye
- Thyroid

24 Conditions
Pediatric Video Visits (4-17 years)*

- Acne
- Allergy
- Burns
- Cold, flu, or sinus infection
- Diarrhea
- Lice
- Rash
- Cuts and scrapes
- Pink eye

Specialty Care

- Endocrinology
- Gastroenterology
- Neurology
- Dermatology
- OB/GYN
- Post-Op Orthopedic Surgery
- Post-Op Plastic Surgery
- Pulmonary Medicine
- Supportive Medicine
- Urology and more

* Video Visits are a covered benefit for many health plans and will accumulate to your MOOP. Check with your health plan for more details. Please note that controlled substances and narcotic pain medications cannot be prescribed.

Hours

Adult Monday – Friday, 8 a.m. to 9 p.m. • Pedi Monday – Friday, 8 a.m. to 5 p.m.
Saturday, Sunday, and Holidays, 10 a.m. to 4 p.m.

(Holiday Hours May Vary)

AETNA WHOLE HEALTH—MEMORIAL HERMANN

Aetna Whole Health — Memorial Hermann Accountable Care Network is a new way of looking at health care. This plan is designed to improve the quality of your care, provide a better experience for you and your family — and do it all while saving you money. You'll have access to a special network of primary care doctors,* specialists and hospitals focused on you. Led by a primary care doctor you pick, your care team will work with you to:

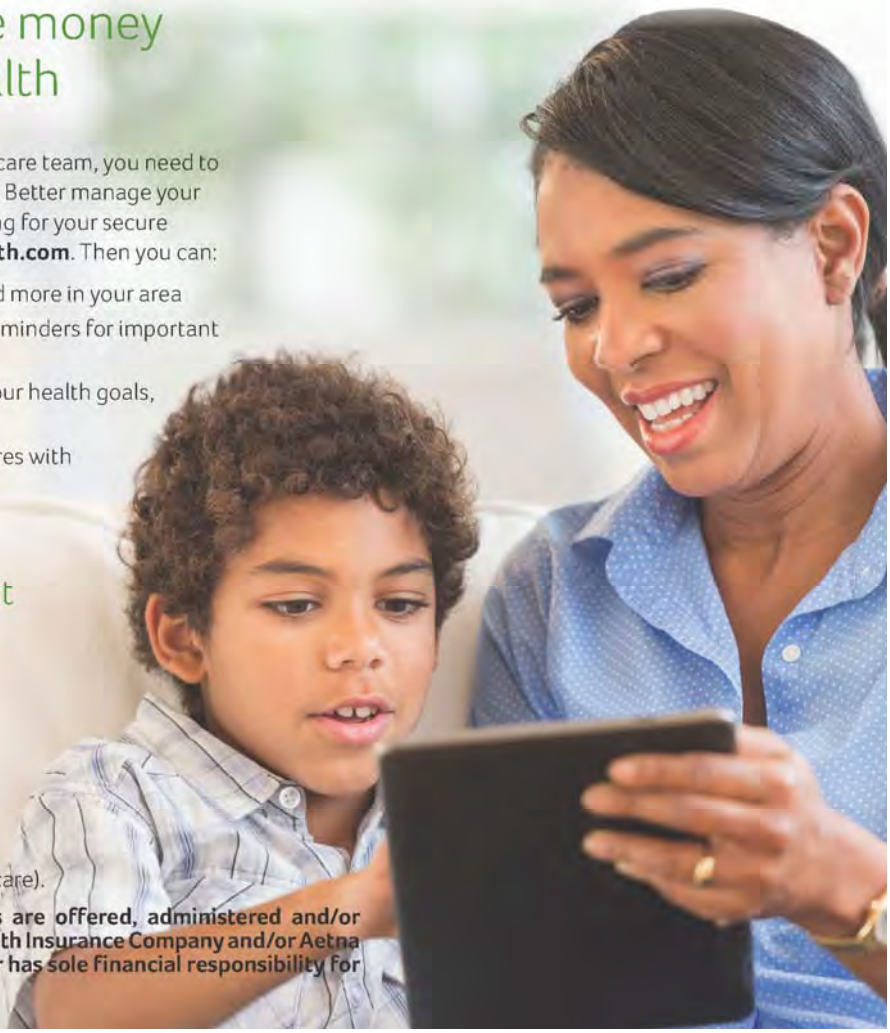
- ✓ **Help keep you healthy or improve your health**, not just treat you when you're sick or injured
- ✓ **Better coordinate your care** and keep tabs on your prescriptions, lab results, health history and more
- ✓ **Spot problems and build personalized care plans** to treat you
- ✓ **Encourage you to play an active and informed role** in your health and health care decisions

Tools to help you save money and manage your health

To be an active and informed member of your care team, you need to be in the know. And we can help get you there. Better manage your plan, your health and your budget by registering for your secure member website at **www.myaetnawholehealth.com**. Then you can:

- Search for doctors, hospitals, pharmacies and more in your area
- Check your personal health record and see reminders for important preventive screenings
- Download the iTriage® app to set and track your health goals, make appointments, and more
- Shop for the best deals on tests and procedures with Member Payment Estimator
- Review your claims and pay your bills

Tip: You'll save money and get more coordinated care when you stay in network and use Aetna Whole Health — Memorial Hermann doctors and hospitals.



*In Texas, PCP is known as physician (primary care).

Health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

KNOW WHERE TO GO

When you get sick or injured, where do you turn?

Because of high cost and long wait times, it's usually best to save ER trips for true emergencies. When you need non-emergency care, try to visit your doctor who can treat you based on a better understanding of your medical history. If your doctor isn't available, you may be able to get the care you need at another facility with shorter wait times and for a lower cost than an ER trip.

Where to Get Care	What It Is	Visit for …	Typical Hours and Wait Time	Cost Level
NurseLine 	NurseLine connects you with registered nurses 24/7. **Aetna NurseLine: 800-556-1555**	Choosing appropriate medical care, finding a doctor or hospital, understanding treatment options, achieving a healthier lifestyle, and answering medication questions.	24/7, little to no wait	**No additional cost**
Virtual Visit (Teladoc or KelseyCare) 	Speak with a doctor by video or phone—on your smart phone, tablet or computer **(see page 9)**	Routine care, like for the flu, infections, nausea, rashes, bronchitis, pink eye or shingles—especially when you're traveling or can't easily get out to see a provider	Hours vary; wait time is typically very short	**$**
Retail Clinic 	Walk-in clinics found in some grocery stores and pharmacies **(For Memorial Hermann ACO and Choice POS II plans ONLY)**	Routine care, like for a sinus infection, minor allergic reaction, fever, rash, cut or flu shot	Includes evenings and weekends; shorter wait time	**$$**
Your Doctor 	Physician with traditional office hours	Ongoing and more personalized care based on an understanding of your medical history; annual check-ups; routine care, like for a sinus infection, minor allergic reaction, fever, rash, cut or flu shot	Traditional office hours; call ahead for appointments	**$$**
Urgent Care 	A stand-alone facility that usually has "urgent care" in the name (and NOT "ER" or "emergency")	Problems that need immediate attention but aren't life-threatening, like stitches, sprains, animal bites and x-rays	Hours include evenings, weekends and holidays; shorter wait time than ER	**$$$**
Traditional ER 	ER attached to a hospital	All life-threatening or disabling conditions, trauma care and major injuries	Open 24 hours; long wait for non-emergency	**$$$$**

Finding an Urgent Care or Walk-In Clinic

Get familiar with the urgent care and walk-in clinics in your neighborhood before you need them.

- Visit **aetna.com and** click on **Find a Doctor**. Select **Urgent Care Facilities** or **Walk-In Clinics**.
- You can also visit **concentra.com** to find a Concentra urgent care clinic near you.

With the Aetna Mobile app, you can:

Set up touch ID

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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Living strong

Be proactive about your health

Prevention is the best medicine

When your doctor diagnoses a health condition early, you may be able to delay or even prevent its problems. Getting early treatment can make your condition easier to manage and put you in control of your health.

Your doctor plays a key role in your care

They may suggest:

- **Screening tests,** which find health problems before symptoms appear
- **Diagnostic tests, physicals and self-exams,** which find health problems early in their course

Your doctor may also use guidelines to recommend screenings based on your age, health, gender, lifestyle habits, family history and, if you're a woman, on whether you are preparing for pregnancy.

If you're thinking about getting a test, it's a good idea to talk with your doctor about what the test is, what it costs and what happens if you need further testing. Together, decide what's right for you.

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Screenings for adults

Adult screenings are intended to find health issues as you age. And many are part of your annual preventive exam.* Talk with your doctor about which screenings are right for you.

Preventive screening	Group	Recommendation
Alcohol and tobacco use	Everyone	Annually
Blood pressure	Everyone	Annually
Breast cancer	Women, aged 50 – 74	Mammogram every 2 years. Talk with your doctor to decide if you need them more often.[1]
Cervical cancer	Women, beginning at age 21	Pap smear for women 21 – 65 years of age every 3 years. Women 30 – 65 years of age may have a Pap smear and human papillomavirus (HPV) testing every 5 years.[2]
Cholesterol	Everyone, beginning at age 35	Annually
Colorectal cancer	Everyone, beginning at age 45	Every 10 years. Talk to your doctor.
Depression	Everyone	Annually
Diabetes	Everyone	Glucose test every 3 years. Talk to your doctor if you are at increased risk.
Lung cancer	Current or former smokers, aged 55 – 80**	Annually
Osteoporosis	Women	For post-menopausal women; or under age 65 at increased risk for osteoporosis
Sexually transmitted diseases	Everyone	Annually
Vision	Everyone	Annually
Weight	Everyone	Annually

*Plan features and availability may vary by location and group size. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change.

**Smokers or former smokers with a 30 pack per year or more smoking history and, if a former smoker, has quit within the past 15 years.

[1]U.S. Preventive Services Task Force. Final recommendation statement. Breast cancer: screening. November 2018.

[2]U.S. Preventive Services Task Force. Final recommendation statement. Cervical cancer: screening. August 2018.

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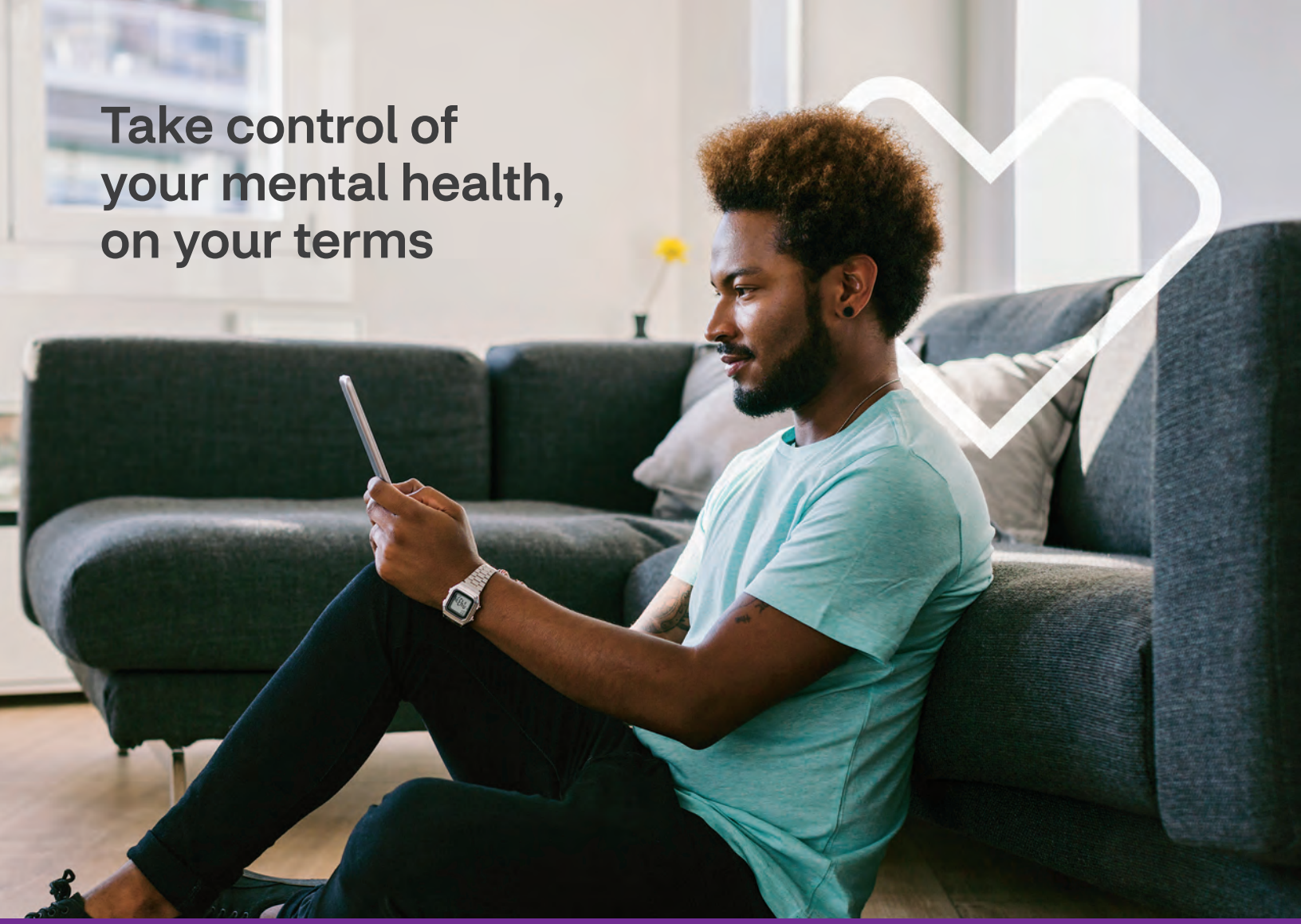
Take control of your mental health, on your terms



Sometimes life can be overwhelming, leading to worry, stress and sadness. These are common feelings with major life changes or chronic pain. But help is now just a phone call away.

With the AbleTo program, you'll get virtual, personalized support that can help you feel better. You'll learn how to better manage your emotions and improve your overall health. And your mental and physical health can improve in as little as eight weeks. Plus, this program is already included in your Aetna® membership.

The program can help you:

- Work through these normal emotions
- Know the types of changes you need to make
- Feel like you're in control of your health and life

Real help that fits your schedule

It's really easy to take the first step. In fact, you can speak to a licensed therapist within seven days or less from calling.

Then, you can attend a private, confidential session virtually, by telephone or secure video chat, right from your home. Simply schedule your sessions at your convenience, including outside normal business hours and on weekends.

So how does it work?

Support when and where you need it

Every week, you'll meet with your experienced care team (a behavioral coach and therapist). You'll work with them to set goals and learn coping strategies in two private sessions per week.

Your team will help you:

Better understand the relationship between thoughts, feelings and actions

Get ahead of challenging issues, including medical conditions, family problems or personal hurdles

Overcome obstacles that keep you from living your best life

Consider AbleTo support if you've had one of these health conditions or life changes:

- Depression, anxiety or panic attacks
- Chronic pain/pain management
- Grief and loss
- Diabetes/weight loss
- Cardiovascular disease
- Caregiver stress (child, elder or person with autism)
- Digestive health issues
- Cancer diagnosis and recovery
- Respiratory issues
- Infertility or postpartum depression
- Alcohol or substance use disorder
- Military transition

Here's what makes this program different

Unlike other telemedicine services, this program has:

- A short-term, eight-week model
- Proven effectiveness
- Therapy plus coaching
- Excellent online member experience
- Flexible scheduling

Easy ways to join the program

We'll call you:

If your claims data shows you may benefit from this program, an Aetna or AbleTo representative will call you to explain how it works and why it can help you. In most cases, there's no cost to you.*

Or you can contact us:

- Visit **AbleTo.com/Aetna**
- Call **1-844-330-3648**, Monday–Friday from 9 AM–8 PM ET
- Tell your Aetna case manager you'd like to participate

95%

of surveyed AbleTo program graduates recommend the program to others.[1]

After just 8 weeks of treatment, graduates reported

50%

improvement in overall health and symptoms of stress, anxiety and depression.[2]

*You may be able to receive AbleTo services with no out-of-pocket cost to you, depending on your employer. With other employers, associated deductibles will apply before your out-of-pocket expenses are covered. Just call the number on your member ID card to learn more about your options.

[1] AbleTo Patient Satisfaction Survey, 2019.

[2] AbleTo Commercial Outcomes, 2019.

Special delivery

Explore the Maternity Support Center

Give your baby a healthy start

If you're thinking about starting a family, already pregnant or a new parent, the Maternity Support Center is a great resource for you, your spouse or your partner.

And while it can be a very exciting time in your life, the amount of information about pregnancy and parenting can be overwhelming. So take comfort in knowing you have a trusted, reliable resource for maternity health and benefits information.

Aetna.com

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Support for all stages

You'll find helpful information for each stage of your journey. Here are just some of the highlights:

Before pregnancy

- Tips for a healthy pregnancy
- Questions to ask when starting a family
- Choosing a doctor and care team
- Understanding your benefits

During pregnancy/delivery

- What to expect in each trimester
- The importance of prenatal visits
- Signs of preterm labor
- Information on labor and delivery, breastfeeding and breast pumps

Caring for your baby at home

- First-year checklist
- Recommended immunization schedule
- Car seat safety
- Helpful sleep tips

Taking care of yourself

- What to expect at your post-pregnancy checkup
- How to quickly find answers about family health
- Understanding "baby blues" and postpartum depression
- Contraception and baby spacing

Get information when it matters most

We're here to give you the information you need during this special time. Whether you want advice on how to safely put your baby to sleep or quick tips to get through those 3 AM feedings, count on us to help.

Visit us before, during and after your pregnancy

- Go to **Aetna.com** and log in to your member website.
- Choose "Stay Healthy."
- Select "Maternity Support Center."

Questions?
Just call the number listed on your ID card.

Aetna.com

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PRESCRIPTION DRUG PROGRAMS

NAVITUS • 855-673-6504 • navitus.com

Mail Order

Get maintenance medications (those you take for an extended period of time) delivered to your door using NoviXus Mail Order. It is easy to start using NoviXus. You can sign up online at **novixus.com**. You can also call NoviXus to enroll. They can be reached toll free at 1-888-240-2211. Please allow 10 to 14 calendar days from the day you submit your order to receive your medicine(s).

Mandatory Specialty Program

Navitus SpecialtyRx helps members who are taking medicine(s) for certain chronic illnesses or complex diseases. It provides services that offer convenience and support. This program is part of your pharmacy benefit and is mandatory. Ordering new prescriptions with this pharmacy is simple. Just call a Patient Care Specialist to get started. They can be reached at 855-847-3553.

Navi-Gate Member Portal

Navi-Gate is the secure member portal for Navitus, where you can find information specific to your plan. You will need your pharmacy benefit unique ID to log into Navi-Gate for Members. Please contact Navitus Customer Care at 855-673-6504 for your pharmacy benefit unique ID. To find the portal, go to **navitus.com** and click on **Members**, then **Member Login**.

GOODRX

GoodRx can help you find the best deals on prescriptions in your area. Visit **goodrx.com**, or download the GoodRx app to use it on the go.

- Get instant access to the lowest prices at more than 75,000 pharmacies
- Find coupons and savings tips
- See drug side effects, pharmacy hours and locations, pill descriptions and more

Keep in mind, GoodRx shows the cash price and does not take insurance into account.

Experiencing the Navitus Difference

Navitus Health Solutions is proud to be your pharmacy benefit manager (PBM).

What Does a PBM Do?

As your PBM, Navitus is committed to providing you with robust, 360-degree support when it comes to your pharmacy benefits. You can count on us to:

Make it easier to understand your benefits with our member portal* and mobile app, where you can:

- Check your medication history
- Compare drug prices
- Locate convenient pharmacies within your network

Give you convenient access to more affordable prescriptions through our network of nationwide retail pharmacies and mail order (if applicable)

Provide timely and accurate answers to questions about your medications and pharmacy benefits

Give you the medication support you need through one simple phone call or with the click of a mouse

Experience the Navitus difference for yourself. Register for Navitus' secure member portal at www.navitus.com/members or on your plan's website, or download the mobile app today!**

*The portal is for active members only. Available features may vary by plan. Your out-of-pocket costs may vary based on drug costs, plan design and contracts.

**The mobile app, and individual features of the app, may not be available for all benefit plans managed by Navitus, or for every member of each plan. Please refer to your plan for more information. Mobile app registration is simple and secure and may require your member ID. The app is available to iOS and Android users. You must be 18 years or older and currently covered under Navitus' pharmacy benefit plan. Hover your phone's camera over the code to download the app. For mobile app account assistance, contact Customer Care: 1.855.673.6504. Open 24 hours a day, 7 days a week.

Download on the App Store

GET IT ON Google Play

NAVITUS
PHARMACY BENEFITS REINVENTED™

4 Ways to Save Money on Your Prescription Drug Costs

Everyone likes to save money. Here are a few strategies to help you save on your prescriptions:

1. Consider a generic substitute, which is often less expensive than the brand-name drug.
2. Take advantage of 90-day refills, which may mean fewer trips to the pharmacy and lower copays.
3. Ask your prescriber about tablet splitting to save up to 50% on out-of-pocket costs for select medications.
4. Compare prices before you visit the pharmacy using our convenient online resources to help you save money.

The 90-Day Refill Advantage

Visit the secure member portal at www.navitus com/members or on your plan's website, or download Navitus' mobile app* to learn more.

*The mobile app, and individual features of the app, may not be available for all benefit plans managed by Navitus, or for every member of each plan. Please refer to your plan for more information. Mobile app registration is simple and secure and may require your member ID. The app is available to iOS and Android users. You must be 18 years or older and currently covered under Navitus' pharmacy benefit plan. Hover your phone's camera over the code to download the app. For mobile app account assistance, contact Customer Care: 1.844.268.9789. Open 24 hours a day, 7 days a week.

Download on the App Store

GET IT ON Google Play

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PHARMACY BENEFITS REINVENTED™

 2447-1020CL

Save More Money with Generics vs. Brands

If you choose a generic drug instead of a brand drug, you can save money. The chart below shows an example of the possible savings you can get from switching.

Are you wondering if your current brand drug has a generic substitute? Ask your prescriber or pharmacist if a generic drug would work for you in place of a brand drug you are using now.

Example of savings using generic medications:

Drug Type	Quantity	Average Cost Per Month
Brand	40 mg	$140.00
Generic	40 mg	$14.00

With this example, total cost savings per year is $1,512.00!

Visit www.navitus.com or your plan's website to explore more ways you can save on your medication.

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 2444-1020CL

Compare Prices and Find Pharmacies Using Cost Compare

Did you know that not all pharmacies charge you the same amount for the same prescription? Look up prices before you leave for the pharmacy and save. Cost Compare lets you:

- Check Rx prices at local pharmacies
- Estimate your cost in real time
- Search based on your prescription history

Have questions about your pharmacy benefits? Answers are just a click away!

Information about your pharmacy benefit and tools to help you get your prescriptions are available at your fingertips. Visit Navitus' secure member portal at www.navitus.com or log onto your plan's website to access your:

- Cost Information
- Medication History
- Pharmacy Search
- Drug Search
- Drug Side Effect and Interaction Search

This portal is for active members only. Available features may vary by plan. Your out-of-pocket costs may vary based on drug costs, plan design and contracts.

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PHARMACY BENEFITS REINVENTED™

 2443-1020CL

RETIREE MEDICAL

Retiree Rates:

Please call the Trust Office at 713-643-9300 for information regarding retiree rates.

SHORT TERM DISABILITY COVERAGE

713-643-9300 • www.benefitresourcesinc.com

Once you have met your initial eligibility requirements you will automatically be enrolled in the Short Term Disability program. In order to maintain your coverage under the Short Term Disability program, all members must work 140 hours or more per month. After being totally disabled for 7 days due to a non-work related covered accident or sickness, and if your disability is approved by the insurance company, you will be eligible to receive a weekly benefit of up to $250, (not to exceed 70% of weekly salary). This benefit could last for up to 26 weeks as long as you continue to meet the definition of disabled. The benefit reduces to 50% at age 70. You may be considered totally disabled if you are unable to perform each of your main duties of your occupation. If you are unable to perform one or more of your main full-time duties, you may be eligible for a partial disability benefit.

Short Term Disability is not available to Retirees.

Disability Claims Contact Information

Benefit Resources
8441 Gulf Freeway Suite304
Houston, TX 77017
Phone: 713-643-9300
Fax: 866-316-4794

Process for Submitting Short Term Disability Claims

Short Term Disability claims can be submitted to Benefit Resources in one of the following ways:

- Traditional Claim form (faxed or mailed)

Short Term Disability Claims Timing:

- Claim receipt is formally acknowledged (via letter) within 2 business days of receipt
- Claim is immediately assigned to Dedicated STD Benefit Analyst for administration
- To expedite claim decisions, outreach for missing information is generally done via phone, fax and/or email.

National Vision Administrators, L.L.C. dba E-NVA, L.L.C.

Your NVA Vision Benefit Summary

Electrical Medical Trust
Effective 07/01/2023
Group Number# 3358

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every Plan Year	▪ Covered 100% After $10 copay	Reimbursed Amount ▪ Up to $45
Lenses Once Every Plan Year ▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	Standard Glass or Plastic ▪ Covered 100% After $15 copay	 ▪ Up to $30 ▪ Up to $50 ▪ Up to $60 ▪ Up to $80
Frame Once Every Two Plan Years	Retail Allowance ▪ Up to $200 After $15 copay (20% discount off balance)*	▪ Up to $50
Contact Lenses Once Every Plan Year Elective Contact Lenses Medically Necessary***	In lieu of Lenses & Frame ▪ Up to $200 Retail① After $15 copay (15% discount (Conventional) or 10% discount (Disposable) off balance)** ▪ Covered 100%	In lieu of Lenses & Frame ▪ Up to $100 ▪ Up to $200

*Does not apply to Costco, Wal-Mart / Sam's Club or Lenscrafters locations or for certain proprietary brands. **Does not apply to Costco, Wal-Mart/Sam's Club, Lenscrafters, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers. ***Pre-approval from NVA required.

①Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

Fixed prices/courtesy discount do not apply at Costco, Walmart/Sam's Club and LensCrafters locations.
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $75 Polarized
- $30 Blended Bifocal (Segment)
- $40 Blue Light Blocker (Standard)
- $60 Blue Light Blocker (Premium)
- $150 Blue Light Blocker (Ultra)
- $12 Fashion Gradient
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $55 High Index
- $12 Ultraviolet Coating
- $25 Polycarbonate (Single Vision)
- $30 Polycarbonate (Multi-Focal)
- $10 Scratch-Resistant Coating (Standard
- $65 Transitions Single Vision (Standard)
- $70 Transitions Multi-Focal (Standard)
- $10 Solid Tint
- $40 AR Coating – Tier 1
- $50 AR Coating – Tier 2
- $65 AR Coating – Tier 3
- $80 AR Coating – Tier 4
- 20% discount AR Coating – Tier 5
- $50 Progressive Tier -1
- $80 Progressive – Tier 2
- $100 Progressive – Tier 3
- $120 Progressive – Tier 4
- $140 Progressive – Tier 5
- $165 Progressive – Tier 6
- $190 Progressive – Tier 7
- 20% discount Progressive – Tier 8
- $39 Retinal Screening

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., Costco, LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses once every plan year and a frame once every two plan years or contact lenses once every plan year.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision or contact NVA's Customer Service Department toll-free at 1.800.672.7723, TTY: 711 or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 3358000001 or the group number on the identification card and enter in your search parameters. It's that easy!

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations*:* The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only		
Service	**Participating Provider**	**Lens Options**
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint
		$50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses
		$65 Transitions Single Vision Standard
Lenses:	Glass or Plastic	$70 Transitions Multi-Focal Standard
Single Vision	$35.00	$15 Standard Scratch Coating
Bifocal	$55.00	$12 UV Coating
Trifocal or Lenticular	$70.00	$35 Polycarbonate
		$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.

Costco, Wal-Mart / Sam's Club and Lenscrafters stores do not provide additional discounts.

Some optometrist affiliated with Optical Retail locations (i.e., Costco, LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

Exclusions / Limitations*:* No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

COUNCIL 13 AFSCME UNION LABEL

Please see below Active Life and Accidental Death & Dismemberment Plan Design. There is no action needed on your part.

Life Benefits	
Under Age 65	$15,000
Age 65 to 69	$9,750
Age 70 and over	$7,500
AD&D Benefits	
Under Age 65	$15,000
Age 65 to 69	$9,750
Age 70 and over	$7,500

The Union Labor Life Insurance Company
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910
Attention: Group Life Claims Unit

Telephone Number: 1- (202) 682-6768
Toll Free Number: 1- (866) 795-0680
Fax Number: 1-(860) 761-1830

Our hours of operation are Monday to Friday from 8:00 a.m. to 4:30 p.m., Eastern Time. You may also visit us at the web at www.ullico.com.

Electrical Medical Trust
IBEW Local Union 716

PRIVACY NOTICE

PURPOSE OF THIS NOTICE AND EFFECTIVE DATE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date. The original effective date of this Notice is April 14, 2003. The revised effective date is December 13, 2019.

This Notice is required by law. The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI),
- Your rights to privacy with respect to your PHI,
- The Fund's duties with respect to your PHI,
- Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and
- The person or office you should contact for further information about the Fund's privacy practices.

YOUR PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose Your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- ***At your request.*** If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect and/or copy it.
- ***As required by HHS.*** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.
- ***To your personal representative, as more fully set forth below.***
- ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI in order to carry out treatment, payment, or health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates." We will also disclose enrollment information to contributing employers and union representatives.

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example the Fund may use information about your claims to refer into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

Disclosure to the Fund's Trustees. The Fund will also disclose PHI to the Fund Sponsor, which is the Board of Trustees of the Painters & Allied Trades District Council No. 35 Health Fund, for purposes related to treatment, payment, and health care operations, and has amended the Fund Documents to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan may provide health information for the purpose of evaluating and processing a claim for Health Fund accident and sickness benefits; for evaluating an application for death benefits from the Pension Fund and/or Annuity Fund; or for evaluating a member's vested status under the Pension Fund. However the Plan will obtain your written authorization before it will use or disclose any health information for these purposes.

In addition, the Fund must generally obtain your written authorization before each of the following uses or disclosures:

- Using or disclosing psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed - notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Fund is not likely to have access to or maintain these types of notes.
- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Fund receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.
- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

When You Can Object and Prevent the Fund from Using or Disclosing PHI

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose, without your written consent or authorization, is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of PHI Without Consent, Authorization or Opportunity to Object

The Fund is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. ***When required by applicable law.***
2. ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been, or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. ***Health oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud, or oversight activities of the Department of Labor).
5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that

    - The requesting party must give the Fund satisfactory assurances a good faith attempt has been made to provide you with written notice,
    - The notice provided sufficient information about the proceeding to permit you to raise an objection, and
    - No objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).
7. ***Law enforcement emergency purposes.*** For law enforcement purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and the Fund in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include the following:

    - identifying or locating a suspect, fugitive, material witness or missing person, and
    - disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8. ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.
10. ***Research.*** For research, subject to certain conditions.
11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Any other Fund uses and disclosures not described in this section will be made only if you provide the Fund with written authorization, subject to your right to revoke your authorization.

Other Uses or Disclosures

The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

YOUR INDIVIDUAL PRIVACY RIGHTS

Following is a description of your individual privacy rights. The Fund contracts with several vendors, also called "business associates," who provide services to the Fund and services and benefits to you on the Fund's behalf. Once the Fund is notified that you choose to invoke any of the individual rights listed below, it will notify the appropriate vendor on your behalf. Because some of your PHI is maintained and used by these Business Associates to provide or process your benefits, the Fund requires that they administer certain aspects of the individual privacy rights. **You may contact the Privacy Official at the address and phone number listed below:**

Cory Crandell, Privacy Official
Electrical Medical Trust
8441 Gulf Freeway, Suite 304
Houston, Texas 77071
Phone (713) 643-9300
Fax (866) 316-4794

You May Request Restrictions on PHI Uses and Disclosures

You have the right to request that the Plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the Plan restrict the use and disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Official listed at the address listed at the end of this Notice and must state the specific restriction requested and to whom that restriction would apply.

The Fund, however, is not required to agree to your request if the Fund Administrator or Privacy Official determines it to be unreasonable.

You May Request Confidential Communications

The Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure through regular means could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy Official at the address listed at the end of this Notice.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) contained in a "designated record set," for as long as the Fund maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Fund will honor that request to the extent possible. You also may request a summary of your PHI. The Fund must provide the requested information within 30 days.

A single 30-day extension is allowed if the Fund is unable to comply with the deadline and if the Fund provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

You or your personal representative will be required to complete a form to request access to the PHI. You may be charged a reasonable, cost-based fee for creating or copying the PHI, or preparing a summary of your PHI. Requests for access to PHI should be made to the Privacy Official at the address listed at the end of this Notice.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and HHS.

Your PHI includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained to make decisions about you.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you for as long as the PHI is maintained. The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend PHI to the Fund's Privacy Official (at the address listed at the end of this Notice). You or your personal representative will be required to complete a form to request amendment of the PHI.

The covered entity may require individuals to make requests for amendment in writing and to provide a reason to support the requested amendment. The Fund must inform individuals in advance of such requirements. The Fund may deny your request.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. Accounting requests may not be made for periods of time going back more than six years.

If you request more than one accounting within a 12-month period, the Fund may charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address listed at the end of this Notice. This right applies even if you have agreed to receive the Notice electronically.

Your Personal Representative

You may exercise your rights through a personal representative who will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider a spouse to be the personal representative of an individual covered by the Fund. In addition, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse, a parent or child may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Fund restrict information that goes to family members as described above at the beginning of this section.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

THE FUND'S DUTIES

Maintaining Your Privacy

HIPAA requires the Fund to maintain the privacy of your PHI and to provide you with notice of its legal duties and privacy practices. In addition, the Fund may not (and does not) use your genetic information that is PHI for underwriting purposes.

The Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

If material changes are made to this Notice, the Notice will be posted on the Fund's website no later than the effective date of the revision and thereafter sent in the Fund's next annual mailing.

Material changes are changes to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the United States Department of Health and Human Services, pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA.

YOUR RIGHT TO FILE A COMPLAINT WITH THE FUND OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the Privacy Official at the address listed below.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services (HHS). Filing instructions are available at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.

The Fund will not retaliate against you for filing a complaint.

IF YOU NEED MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at National Electrical Contractors Association, IBEW Local 716 Electrical Medical Fund, by phone 1-(713) 643-9300, or by mail at 8441 Gulf Freeway, Suite 304, Houston, Texas 77017.

CONCLUSION

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

Electrical Medical Trust

General Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when your group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review your Summary Plan Description (SPD) or contact the Fund Office at 1-(713) 643-9300.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (Exchange). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for special enrollment during the applicable period under another group health plan for which you are eligible (such as a spouse's plan).

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must self-pay for COBRA continuation coverage as provided under the terms of the Plan.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Note: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the NECA IBEW Fund, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Fund Office of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

The employee, or covered eligible family member must notify the Fund Office of the following qualifying events within 60 days of the event:

- Divorce or legal separation of the employee and spouse;
- Dependent child losing eligibility because of reaching age 26;
- Acquisition of a new dependent to be added to COBRA coverage such as the birth of a child, adoption or placement for adoption of a child.

Note: The Fund office will require the applicable documentation to support the qualifying event as applicable. You will be required to cooperate with the Fund office and Plan Administration to provide the necessary documentation.

General Notice of COBRA Continued

How is COBRA continuation coverage provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide documentation of the Social Security determination, to the Fund office, postmarked no later than 60 calendar days after the later of the date: (a) of the disability determination by the Social Security Administration; (b) on which the qualifying event occurs; or (c) on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Fund office is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group

health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Fund Office know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund office and Plan Administrator.

Plan contact information

You may contact the Fund office at 1-713-643-9300, between the hours of 9:00am and 4:30pm Monday thru Friday with any questions you have regarding COBRA continuation coverage.

Electrical Medical Trust

Women's Health and Cancer Rights Act Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance as set forth in the applicable SBC will apply.

If you would like more information on WHCRA benefits, call the Fund office at 1-713-643-9300 between the hours of 9:00am and 4:30pm, Monday thru Friday.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)